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Case conference

Changing direction in general practice

This case conference steps aside from the usual pattern to examine the arguments of a general practitioner, Dr Brian Fisher, who wishes to change the style of his practice but is concerned about the consequent problems he can foresee. He discussed his ideas with a local health visitor and a number of neighbouring general practitioners.

Those participating were Mrs Sylvia Prentice, health visitor, and Dr Brian Fisher, Dr John Hitchens, Dr Raymond Pietroni and Dr L A Rubens. Dr Roger Higgs, organiser of the case conference series, was in the chair.

Let patients be responsible for their own health

DR FISHER

I am interested in extending general practice and so extending patients' capacity to take responsibility for their own health. Patients have problems in dealing with their illnesses for a number of different reasons. They lack autonomy in their lives: they lack control over housing, jobs, education and their health; they get little useful understandable information about their health, faced with the hierarchical structure of the health services. They have a profound lack of confidence in their capacity to understand health concepts and they feel unable to cope with illness. This is compounded when doctors are unable to communicate with the patient: and the reasons often advanced for that are that doctors have very little time, little interest in developing communications and their social and intellectual background may separate them from their patients. There is gross inequality in the status that doctors have in relation to their patients: they are powerful, they can manipulate the system, they are very articulate. I am suggesting some solutions to these difficulties, but they have a number of ethical difficulties.

I wish to involve patients in our work in all sorts of ways – in running health centres, in understanding the structure and the economics of the health service, in the creation of health education, in contrast to just receiving ready-made information. In particular I am interested in involving patients in the treatment of their own and other people's illnesses; for instance, controlling their own blood pressure, understanding the details of their disease, distributing information about health, in groups; extending the type of involvement that has been going on for some time in, for instance, diabetes, to areas which have been hitherto almost entirely the doctors' province. This might extend to other people's illnesses – screening for hypertension, for instance.

A network of patients around the surgery

To do this I should like to create a network of patients around the surgery. Each patient of a group would find out high-quality information for themselves about their own problems, and the general practitioner might refer particular people to them, the drug prescribing coming from the doctor, but a lot of information and explanation coming from other patients. They would thus gain confidence in handling their own health. It would demystify the doctor. Patients would gain more understanding of how doctors' decisions are made, and they could compare their experience with that of other people. Let me give an example.

Two patients went for a termination of pregnancy at the same time. One was clear in her mind what she wanted to do and knew about the operation: the other was much more confused and frightened, and it occurred to me that she would benefit by meeting someone who had had the experience, so I put her in touch with the first patient who by then had just had her operation and they discussed the problems over a number of days. When I saw the second patient afterwards, she said she would not have been able to cope without this help, and it had been an exciting experience, and she declared that she would like to help others who were going through a termination. I have since referred two others to her. This has been a difficult experience for her, and she has had to relive her experiences. She actually found the counselling a tremendous strain, and I had to spend a long time with her afterwards but the person whom she talked with gained a great deal.

However, I am worried that one day someone might be damaged by this type of counselling. What are my responsibilities? How good are we doctors at our job? Could others do better?

DR HIGGS
Let's look first at the idea of group work that Dr Fisher has outlined for us.

Other forms of pressure on the patient

DR HITCHENS
I am not happy with your concept of patients as uneducated in their understanding of health problems. The level of understanding must vary from person to person and area to area. Equally, those who are drawn into groups will form yet another select body who may become as estranged from the patients as the doctors are.

DR RUBEN
I don't think it is as difficult as you make out. For years patients have been giving each other important information, and doctors are only part of the spectrum of information that patients perceive. They may be showered with advice and help from extended family and friends. Also, groups such as those for diabetics and alcoholics have been running successfully for years, although the numbers involved in each practice are small and you should go to the national organization for help. You are trying to put your patients in a gilded cage.

MRS PRENTICE
In the inner city where we work, the extended family doesn't exist any more.

DR PIETRONI
That is one of the hidden objectives of Dr Fisher's idea: to form again some community living which has been decimated by modern life. But I am unhappy with the leap from 'increasing autonomy' to 'groups', and this leap involves all sorts of assumptions. To caricature your political views: if doctors, middle class, articulate, are bad, and patients, ordinary, inarticulate are good, then the paradox is that your solution is a middle-class one, and many people will not feel at ease or find any answers in groups. Leading a group and counselling are difficult skills and there are few who are gifted in this direction naturally. I am worried about the assumption that people who partially share experiences can help each other on this level. Real counselling involves setting aside one's own experience, not dragging the other along the same path.

MRS PRENTICE
Counselling may be the wrong word – it has quasi-professional connotations. What is needed is people who can talk together on a level. Sharing experiences is so important: you are in the company of someone who has had to cope with the same problem.

DR HIGGS
We must define our tasks not by how good we are at them but what we actually do. When we come to look at the women going for termination of pregnancy, the word 'counselling' has covered two separate areas of discussion, which should be separated as much as humanly possible both in the minds of doctors and patients. The first is the decision as to whether to terminate the pregnancy or not: the second is to have support in going through an unpleasant experience. In the latter, patients who have been through (and come out of) a similar experience may be ideal, and the doctor well fulfils his responsibility by referring like this. Before the decision is reached, though, if the doctor is keen to help the patient to have a termination it would be much more ethical and logical at this earlier stage to refer her to a patient who had decided against an abortion and was now looking after her child. Otherwise we are just another form of pressure on the patient and are not allowing her to reach her own decision. The outcome depends enormously on this, and if the decision is right, and support good, I do not think many will need the help of counsellors, supporters or groups afterwards.

DR HITCHENS
Are there patients who should not be in groups? I'm sure the less truly 'medical' the problem, the more help groups can give – as in pregnancy, bereavement, drinking, truancy. The more you enter a medical field, the more you need an expert.

DR FISHER
But most doctors do not give patients information and help except in a limited therapeutic way. Patients could manage all sorts of medical problems themselves – such as hypertension. They could learn about the drugs and the side effects, even considering changes in therapy themselves, although of course this would finally be in the doctors' hands.

DR HIGGS
I am very concerned that the baby will be lost as the bath water splashes out. If my child has meningitis, I want an expert paediatrician to decide on his management, not a group. If my wife has an abnormal abdominal sensation, a skilled doctor is what we want to examine and tell us that it is not, or that it is, cancer. This is a power that society has given to doctors, and it is one that society needs. Patients need help with the overwhelming anxieties that come to them when they are ill. If you like, patients come to be hugged. There is nothing in a paternal or maternal role here for the doctor to be ashamed of.

DR FISHER
But if others have information, why can't we hug one another? There is a tendency to professionalized complexity, and patients are trapped into

believing all sorts of powers that doctors have that don't exist and into abdicating responsibility for their own health.

DR PIETRONI
Surely the most obvious solution is to improve the training of doctors?

MRS PRENTICE
Even better would be for the general public to influence the selection of medical students. But at present there is no way in for outsiders – it's just a closed shop.

DR HIGGS
We have only looked at a few of Dr Fisher's problems. However, I think that there is an analogy with more orthodox therapy in that we can only continue to use a new drug if we are prepared to be constantly vigilant to note any side effects of its use. Likewise, I think the only ethical way of resolving our dilemmas about responsibility with lay groups and counselling is to study what actually happens when we do use them, and both support the groups and follow up the patients as carefully as we can.